

01921

MARYLAND 1937

STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH- COUNTY <u>QUEEN ANNES</u> MARYLAND CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>MILLINGTON</u> TOWN <u>MILLINGTON</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>00</u>				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>MARYLAND</u> COUNTY <u>QUEEN ANNES</u> CITY (If outside corporate limits, write RURAL and give nearest town) <u>MILLINGTON</u> TOWN <u>MILLINGTON</u> STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED (First) <u>WILLIAM</u> (Middle) <u>HALL</u> (Last) <u>BONWILL</u> (Type or Print)				4. DATE OF DEATH <u>FEB. 27</u> 19 <u>55</u>			
5. SEX <u>MALE</u>		6. COLOR OR RACE <u>WHITE</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>APRIL 9, 1869</u>	
9. AGE last birthday <u>85</u> yrs.		10. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>FARMER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>MARYLAND</u>	
13. FATHER'S NAME <u>EUGENE M. BONWILL</u>				14. MOTHER'S MAIDEN NAME <u>PENNINGTON</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If year, give war or dates of service) <u>—</u>				16. SOCIAL SECURITY No. <u>NONE</u>			
17. INFORMANT AND ADDRESS <u>EMORY BONWILL CHESTERTOWN, MD.</u>				18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH				INTERVAL BETWEEN ONSET AND DEATH			
(a) Immediate cause <u>331X</u>				<u>2 weeks</u>			
(b) Antecedent cause(s) <u>Generalized Arteriosclerosis</u>				<u>several years</u>			
(c) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last <u>wine</u>							
II. OTHER SIGNIFICANT CONDITIONS							
Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>none</u>				19b. MAJOR FINDINGS OF OPERATION <u>—</u>			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>—</u>		PLACE (Home, farm, factory, street, OF office bldg., etc.) <u>home</u>		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY <u>home</u> m.		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input checked="" type="checkbox"/>		HOW DID INJURY OCCUR? <u>none</u>			
22. I hereby certify that I attended the deceased from <u>Feb</u> , 19 <u>55</u> , to <u>Feb 27</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 26</u> , 19 <u>55</u> , and that death occurred at <u>1:30</u> P.M., from the causes and on the date stated above.							
SIGNATURE <u>H. H. Hamilton</u>				ADDRESS <u>M.D. Millington MD</u>		DATE SIGNED <u>Feb 27/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE <u>MAR. 1, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>STILL POND CEMETERY</u>		LOCATION (City, town, or county) (State) <u>STILL POND MD.</u>	
DATE REC'D BY LOCAL REG. <u>Mar. 3</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>		24. FUNERAL DIRECTOR <u>B. P. Fellows</u> ADDRESS <u>STILL POND, MD.</u>			

MARGIN RESERVED FOR BINDING

BUREAU V. S.

MAR 7 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1938

01923

Reg. Dist.

No. 252

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. PLACE OF DEATH:				2. USUAL RESIDENCE (HOME) OF DECEASED:			
COUNTY <u>Queen Anne's</u>		MARYLAND		STATE <u>Maryland</u> COUNTY <u>Queen Anne's</u>			
CITY (If outside corporate limits, write RURAL OR and give nearest town)		LENGTH OF STAY (in this place)		CITY (If outside corporate limits write RURAL and give nearest town)			
X TOWN <u>Centerville</u>		<u>None</u>		TOWN <u>Rural Centerville</u> X			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
				<u>Perles. Quantown Road</u>			
3. NAME OF DECEASED: (Type or Print)		(First) (Middle) (Last)		4. DATE OF DEATH		(Month) (Day) (Year)	
<u>WILLIAM</u>		<u>MARION COONEILL</u>		<u>July 12</u>		<u>1951</u>	
5. SEX:	6. COLOR OR RACE:	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify):	8. DATE OF BIRTH:	9. AGE last birthday:	IF UNDER 1 YEAR		IF UNDER 24 HRS.
<u>Male</u>	<u>White</u>	<u>Single</u>	<u>July 31-1888</u>	<u>65</u> yrs.	Months	Days	Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired):		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country):		12. CITIZEN OF WHAT COUNTRY?	
<u>Retired</u>		<u>From Maryland</u>		<u>Centerville Maryland</u>		<u>USA</u>	
13. FATHER'S NAME:				14. MOTHER'S MAIDEN NAME:			
<u>Robert H Cooneill</u>				<u>Martha Ann Sparks</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY No.:		17. INFORMANT & ADDRESS:			
<u>Yes</u> <u>WW #1</u>				<u>Ann Lillian E Rouse 1701 Better St Baltimore Md</u>			
18. MEDICAL CERTIFICATION						INTERVAL BETWEEN ONSET AND DEATH	
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH:							
<u>420.1</u>							
Immediate cause (a) <u>Coronary Occlusion</u>							
DUE TO							
Antecedent cause(s) (b) <u>He was found dead in a snow drift in</u>							
Diseases or conditions, if any, giving rise to the above cause (c) <u>his yard - He has had heart disease for last 24</u>							
stating underlying cause last							
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION:				19b. MAJOR FINDING OF OPERATION:		20. AUTOPSY?	
<u>0</u>						Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc., INJURY		21c. (City or town) (County) (State)			
21d. TIME (Month) (Day) (Year) (Hour) OF INJURY		21e. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21f. HOW DID INJURY OCCUR?			
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> .							
SIGNATURE				CHIEF MEDICAL EXAMINER <input type="checkbox"/> DATE SIGNED			
<u>W. Henry Fairclough</u>				<u>2/15-55</u>			
DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ASSISTANT MEDICAL EXAM. <input type="checkbox"/>			
23. BURIAL, CREMATION, REMOVAL (Specify):		DATE THEREOF		NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<u>Burial</u>		<u>July 16-55</u>		<u>Centerville</u>		<u>Centerville Maryland</u>	
DATE REC'D BY LOCAL REG.		REGISTRAR'S SIGNATURE		24. FUNERAL DIRECTOR		ADDRESS	
<u>2-15-55</u>		<u>Oliver R. Rouse</u>		<u>Barton Bros Centerville Maryland</u>			

BUREAU V. S.

FEB 21 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1939

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

01924

CERTIFICATE OF DEATH

Reg. Dist. No. 254

tem 11, Film G178 3-15-55 et

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND		2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q.A.</u>	
CITY (if outside corporate limits, write RURAL and OR give nearest town) TOWN <u>Grasonville</u>		CITY (if outside corporate limits, write RURAL and give nearest town) TOWN <u>Grasonville</u>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS		STREET ADDRESS (if rural, give location)	
3. NAME OF DECEASED (Type or Print)	(First) <u>Virgie</u>	(Middle) <u>Vivian</u>	(Last) <u>Greenhawk</u>
4. DATE OF DEATH	(Month) <u>Feb.</u>	(Day) <u>19</u>	(Year) <u>1955</u>
5. SEX <u>F</u>	6. COLOR OR RACE <u>W</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED (Specify) <u>Married</u>	8. DATE OF BIRTH <u>April 25, 1890</u>
9. AGE last birthday <u>64</u> yrs.		10. KIND OF BUSINESS OR INDUSTRY <u>Housewife</u>	
11. BIRTHPLACE (State or foreign country) <u>Stevensville, Md.</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>	
13. FATHER'S NAME <u>Thomas Radcliffe</u>		14. MOTHER'S MAIDEN NAME <u>Margaret Elm.</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>_____</u>	
17. INFORMANT AND ADDRESS <u>Husband - W.T. Greenhawk - Grasonville</u>		18. MEDICAL CERTIFICATION	
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		INTERVAL BETWEEN ONSET AND DEATH	
199.4 Immediate cause (a) <u>Carcinomatosis - Organ of</u>		<u>2 mo.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c) <u>origin uncertain</u>			
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.			
19a. DATE OF OPERATION <u>0</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify)	PLACE (Home, farm, factory, street, OF office bldg., etc.)	(CITY OR TOWN)	(COUNTY) (STATE)
TIME (Month) (Day) (Year) (Hour) OF INJURY	INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>	HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Dec.</u> , 19 <u>54</u> , to <u>Feb.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb 18</u> , 19 <u>55</u> , and that death occurred at <u>1:07</u> p.m., from the causes and on the date stated above.			
SIGNATURE <u>Irwin J. Holt MD</u>		ADDRESS <u>Queenstown, Md.</u> DATE SIGNED <u>2/19/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify)	DATE THEREOF <u>2/21/55</u>	NAME OF CEMETERY OR CREMATORY <u>Spring Hill Cemetery</u>	LOCATION (City, town, or county) (State)
DATE REC'D BY LOCAL REG <u>2/21/55</u>	REGISTRAR'S SIGNATURE <u>Helen M. Aldridge</u>	24. FUNERAL DIRECTOR <u>Maurice E. Leonard & Son</u> ADDRESS	

BUREAU V. B.

MAR 4 1955

RECEIVED

100-200000

PLEASE TYPE OR WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
1940
CERTIFICATE OF DEATH

01925

Reg. Dist. No. 253

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <i>Queen Anne</i>	MARYLAND	STATE <i>Ind.</i>	COUNTY <i>Queen Anne</i>
CITY (If outside corporate limits, write RURAL OR and give nearest town) X TOWN <i>Chester</i>	LENGTH OF STAY (in this place)	CITY (If outside corporate limits, write RURAL and give nearest town) OR TOWN <i>Chester</i>	
HOSPITAL OR INSTITUTION OR STREET ADDRESS <i>00</i>		STREET ADDRESS (If rural give location)	
3. NAME OF DECEASED: (First) (Middle) (Last) <i>KENNSLEY T. GRIMES</i>		4. DATE (Month) (Day) (Year) OF DEATH: <i>Feb. 9 1955</i>	
5. SEX: <i>Male</i>	6. COLOR OR RACE: <i>W.</i>	7. <input checked="" type="checkbox"/> SINGLE <input type="checkbox"/> MARRIED, <input type="checkbox"/> WIDOWED, <input type="checkbox"/> DIVORCED. (Specify):	8. DATE OF BIRTH: <i>Feb. 3 1955</i>
9. AGE last birthday		IF UNDER 1 YEAR Months <i>6</i> Days <i>6</i> Hours <i></i> Min. <i></i>	
10A. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired): <i>None</i>		10B. KIND OF BUSINESS OR INDUSTRY:	
11. BIRTHPLACE (State or foreign country): <i>Maryland</i>		12. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	
13. FATHER'S NAME: <i>Edward E. Grimes</i>		14. MOTHER'S MAIDEN NAME: <i>Marilyn Hampton</i>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service)		16. SOCIAL SECURITY NO. <i>—</i>	
17. INFORMANT & ADDRESS: <i>Edward E. Grimes, Chester, Ind.</i>			
18. MEDICAL CERTIFICATION			INTERVAL BETWEEN ONSET AND DEATH
I DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH			
IMMEDIATE CAUSE <i>770.5</i>			
ANTECEDENT CAUSE (S)			
DISEASES OR CONDITIONS, IF ANY, GIVING RISE TO THE ABOVE CAUSE STATING UNDERLYING CAUSE LAST.			
(A) <i>hemolytic crisis</i>			<i>Feb. 3, 1955</i>
(B) <i>Erythroblastosis foetalis</i>			<i>Feb. 3, 1955</i>
(C) <i>congenital debility</i>			
II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH. <i>premature birth</i>			
19A. DATE OF OPERATION: <i>0</i>		19B. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21A. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		21B. PLACE (Home, farm, factory, OF INJURY street, office bldg., etc.)	
21C. WHERE DID (City or town) (County) (State)		21D. HOW DID INJURY OCCUR?	
21E. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21F. HOW DID INJURY OCCUR?	
22. I hereby certify that <i>Dr.</i> attended the deceased from <i>Feb. 3, 1955</i> , to <i>Feb. 9, 1955</i> , that I last saw the deceased alive on <i>Feb. 9, 1955</i> , and that death occurred at <i>1:35 P.M.</i> from the causes and on the date stated above.			
SIGNATURE <i>Theodor Sattelmaier</i>		DATE SIGNED <i>Feb. 9, 1955</i>	
23. BURIAL, CREMATION, REMOVAL (SPECIFY)		DATE THEREOF	
<i>Burial</i>		<i>Feb. 10</i>	
NAME OF CEMETERY OR CREMATORY		LOCATION (City, town, or county) (State)	
<i>Stevensville</i>		<i>Stevensville Ind.</i>	
DATE REC'D BY LOCAL REGISTRAR <i>Feb. 11, 1955</i>		REGISTRAR'S SIGNATURE <i>Elizabeth Wyster</i>	
FUNERAL DIRECTOR <i>Edgar L. Lane - Church Hill, Ind.</i>		ADDRESS	

1025204353

MAILED FOR DEPT. OF JUSTICE - MAY 1955

RECEIVED MAY 1955

BUREAU V. 81

16 1955

RECEIVED

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01926

1941

CERTIFICATE OF DEATH

Reg. Dist. No. 251

Item 7, Film G177 2-18-55 et

I. PLACE OF DEATH:

COUNTY Queen Anne MARYLAND
CITY (If outside corporate limits, write RURAL and give nearest town) Sudlersville
OR and give nearest town)
TOWN Sudlersville
HOSPITAL OR INSTITUTION OR STREET ADDRESS

2. USUAL RESIDENCE (HOME) OF DECEASED:

STATE Md. COUNTY Queen Anne
CITY (If outside corporate limits, write RURAL and give nearest town) Sudlersville
OR
TOWN Sudlersville
STREET ADDRESS (If rural give location)

3. NAME OF DECEASED:

(First) HARRY (Middle) HUGH (Last) HUDSON
(Type or Print)

4. DATE OF DEATH: (Month) Feb. (Day) 11 (Year) 1955

5. SEX:

M.

6. COLOR OR RACE:

W.

7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) widowed

8. DATE OF BIRTH:

Dec. 27, 1886

9. AGE last birthday:

68 yrs.

IF UNDER 1 YEAR IF UNDER 24 HRS.

Months Days Hours Min.

10a. USUAL OCCUPATION. Give kind of work done during most of working life, even if retired Garage

10b. KIND OF BUSINESS OR INDUSTRY: Automotive Repair

11. BIRTHPLACE (State or foreign country): Md.

12. CITIZEN OF WHAT COUNTRY? U.S.A.

13. FATHER'S NAME:

Samuel Hudson

14. MOTHER'S MAIDEN NAME:

Lucile B. Reed

15 WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) 9

16. SOCIAL SECURITY No.:

216-12-1311

17. INFORMANT'S ADDRESS:

Mrs. Woodrow Montague, Sudlersville Md.

18. MEDICAL CERTIFICATION

1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH

581.0
Immediate cause

(a)

DUE TO

Coronary of Liver

Antecedent causes (s)

Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last.

(b)

DUE TO

(c)

Interval Between Onset And Death

11. OTHER SIGNIFICANT CONDITIONS

Conditions contributing to the death but not related to the disease or condition causing death.

General debility - Arterial Hypertension

19a. DATE OF OPERATION:

0 W

19b. MAJOR FINDINGS OF OPERATION

General debility - Arterial Hypertension

20. AUTOPSY?

Yes ☐ No ☒

21. ACCIDENT SUICIDE HOMICIDE

W

(Specify)

PLACE (Home, farm, factory, street, office bldg., etc.)

(CITY OR TOWN)

(COUNTY)

(STATE)

TIME (Month) (Day) (Year) (Hour) OF INJURY

INJURY OCCURRED While at Work ☐ Not While At Work ☐

HOW DID INJURY OCCUR?

22. I hereby certify that I attended the deceased from Oct. 1954, to Feb. 11, 1955, that I last saw the deceased alive on Feb. 9, 1955, and that death occurred at 3:30 A.M., from the causes and on the date stated above.

SIGNATURE

(Degree or title)

ADDRESS

DATE SIGNED

23. BURIAL, CREMATION, REMOVAL (Specify)

Burial

DATE THEREOF

Feb. 13, 1955

NAME OF CEMETERY OR CREMATORY

Sudlersville Cem.

LOCATION (City, town, or county)

Sudlersville Q. A. Co. Md.

(State)

DATE REC'D BY LOCAL REGISTRAR

2-14

REGISTRAR'S SIGNATURE

Edgar L. Lane

24. FUNERAL DIRECTOR

Edward Fellows

ADDRESS

Millington Md.

BUREAU V. S.

FEB 18 1955

RECEIVED

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18 01927
1942 CERTIFICATE OF DEATH

Reg. Dist. No. 251

1. PLACE OF DEATH:		2. USUAL RESIDENCE (HOME) OF DECEASED:	
COUNTY <u>Queen Anne</u>	MARYLAND	STATE <u>Md</u>	COUNTY <u>Kent</u>
CITY (If outside corporate limits, write OR and give nearest town) <u>Sudlersville</u>	RURAL LENGTH OF STAY (in this place) <u>2 mos.</u>	CITY (If outside corporate limits, write OR TOWN <u>Millington</u>	(If rural give location) <u>+</u>
HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>6 Everett Nursing Home</u>		STREET ADDRESS	
3. NAME OF DECEASED: (First) <u>ETHEL</u> (Middle) <u>CROUCH</u> (Last) <u>MOFFETT</u>		4. DATE OF DEATH: (Month) <u>Feb.</u> (Day) <u>3</u> (Year) <u>1953</u>	
5. SEX: <u>F</u>	6. COLOR OR RACE: <u>W.</u>	7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>Widowed</u>	8. DATE OF BIRTH: <u>Feb. 16, 1869</u>
9. AGE last birthday: <u>85</u> yrs.		10. IF UNDER 1 YEAR (Months) (Days) (Hours) (Min.)	
11a. USUAL OCCUPATION Give kind of work done during most of working life, even if retired: <u>housewife</u>		11b. KIND OF BUSINESS OR INDUSTRY: <u>Own Home</u>	
12. CITIZEN OF WHAT COUNTRY: <u>U. S. A.</u>		13. FATHER'S NAME: <u>Edwin Crouch</u>	
14. MOTHER'S MAIDEN NAME: <u>Frances Ford</u>		15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) (If Yes, give war or dates of service) <u>no</u>	
16. SOCIAL SECURITY No.: <u>none</u>		17. INFORMANT & ADDRESS: <u>Mrs Paul Conrags, Millington Md</u>	
18. MEDICAL CERTIFICATION			
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH		Interval Between Onset And Death	
443X Immediate cause (a) <u>Cerebral Hemorrhage</u>			
Antecedent cause(s) (b) <u>Cerebral Arterio Sclerosis</u>			
Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last. (c) <u>Chronic Myocarditis</u>			
11. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death. <u>Hypertension</u>			
19a. DATE OF OPERATION: <u>W</u>		19b. MAJOR FINDINGS OF OPERATION	
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>			
21. ACCIDENT SUICIDE HOMICIDE (Specify) <u>W</u>		PLACE (Home, farm, factory, street, office bldg., etc.) (CITY OR TOWN) (COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At Work <input type="checkbox"/> HOW DID INJURY OCCUR?	
22. I hereby certify that I attended the deceased from <u>Nov. 12, 1954</u> , to <u>Feb. 3, 1953</u> , that I last saw the deceased alive on <u>Feb. 2, 1953</u> , and that death occurred at <u>3 P.M.</u> , from the causes and on the date stated above.			
SIGNATURE <u>E. J. Mullins</u> (Degree or title)		DATE SIGNED <u>2/4/53</u>	
23. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>		DATE THEREOF <u>Feb. 6, 1953</u>	
NAME OF CEMETERY OR CREMATORY <u>Millington Cem.</u>		LOCATION (City, town, or county) (State) <u>Millington Kent Co. Md</u>	
DATE REC'D BY LOCAL REGISTRAR <u>2-5</u>		REGISTRAR'S SIGNATURE <u>Edgar L. Lane</u>	
FUNERAL DIRECTOR <u>Edward Fellows</u>		ADDRESS <u>Millington Md</u>	

MARGIN RESERVED FOR BINDING

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

3 1/2

1000

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1943

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles Street, Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 253

01928

1. PLACE OF DEATH- COUNTY <u>Queen Anne's</u> MARYLAND				2. USUAL RESIDENCE (HOME) OF DECEASED- STATE <u>Md.</u> COUNTY <u>Q. A.</u>			
CITY (If outside corporate limits, write RURAL and OR give nearest town) <u>Chester</u>				CITY (If outside corporate limits, write RURAL and give nearest town) <u>Chester</u>			
HOSPITAL OR INSTITUTION OR STREET ADDRESS				STREET ADDRESS (If rural, give location)			
3. NAME OF DECEASED (Type or Print)		(First) <u>Lucy</u>		(Middle) <u>JONES</u>		(Last) <u>Roe</u>	
4. DATE OF DEATH		(Month) <u>Feb</u>		(Day) <u>15</u>		(Year) <u>1955</u>	
5. SEX <u>F</u>		6. COLOR OR RACE <u>W</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify) <u>WIDOWED</u>		8. DATE OF BIRTH <u>Jan. 21 1884</u>	
9. AGE last birthday <u>71</u> yrs.		If under 1 year Months Days		If under 24 hrs. Hours Min.			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Housewife</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>—</u>		11. BIRTHPLACE (State or foreign country) <u>Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>USA</u>							
13. FATHER'S NAME <u>Samuel L. Jones</u>				14. MOTHER'S MAIDEN NAME <u>Catherine Thompson</u>			
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u> (If yes, give war or dates of service)				16. SOCIAL SECURITY No. <u>—</u>		17. INFORMANT AND ADDRESS <u>Son - Albert Roe - Chester, Md.</u>	
18. MEDICAL CERTIFICATION							
I. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH						INTERVAL BETWEEN ONSET AND DEATH	
175X Immediate cause (a) <u>Carcinoma of Ovary</u>						<u>1 yr.</u>	
Antecedent cause(s) Diseases or conditions, if any, giving rise to the above cause stating the underlying cause last (c)							
II. OTHER SIGNIFICANT CONDITIONS Conditions contributing to the death but not related to the disease or condition causing death.							
19a. DATE OF OPERATION <u>—</u>				19b. MAJOR FINDINGS OF OPERATION			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21. ACCIDENT SUICIDE HOMICIDE (Specify)		PLACE (Home, farm, factory, street, OF office bldg., etc.) INJURY		(CITY OR TOWN)		(COUNTY) (STATE)	
TIME (Month) (Day) (Year) (Hour) OF INJURY		INJURY OCCURRED While at Work <input type="checkbox"/> Not While At work <input type="checkbox"/>		HOW DID INJURY OCCUR?			
22. I hereby certify that I attended the deceased from <u>Jan.</u> , 19 <u>52</u> , to <u>Feb.</u> , 19 <u>55</u> , that I last saw the deceased alive on <u>Feb. 15</u> , 19 <u>55</u> , and that death occurred at <u>8:45</u> p.m., from the causes and on the date stated above.							
SIGNATURE <u>Irwin J. Hays M.D.</u>		(Degree or title)		ADDRESS <u>Quantico Md.</u>		DATE SIGNED <u>7/15/55</u>	
23. BURIAL, CREMATION REMOVAL (Specify) <u>BURIAL</u>		DATE THEREOF <u>FEB. 18, 1955</u>		NAME OF CEMETERY OR CREMATORY <u>STEVENSVILLE CEMETERY</u>		LOCATION (City, town, or county) (State) <u>STEVENSVILLE, MARYLAND</u>	
DATE REC'D BY LOCAL REG. <u>Feb. 18-1955</u>		REGISTRAR'S SIGNATURE <u>Elizabeth Hopton</u>		24. FUNERAL DIRECTOR <u>W. Thompson Carroll, Esq., Md.</u>			

RECEIVED

FEB 28 1955

BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

1944
MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

01929

Reg. Dist.

No. 257

1. PLACE OF DEATH: COUNTY <u>Luzerne Anne</u> MARYLAND CITY (If outside corporate limits, write RURAL OR and give nearest town) TOWN <u>near Centerville</u> HOSPITAL OR INSTITUTION OR STREET ADDRESS <u>James</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: STATE <u>MD</u> COUNTY <u>Luzerne Anne</u> CITY (If outside corporate limits write RURAL and give nearest town) TOWN <u>Centerville</u> <u>RZU</u> STREET ADDRESS (If rural, give location) <u>1</u>			
3. NAME OF DECEASED: (Type or Print) <u>James Bernard Slaughter</u> (First) (Middle) (Last)				4. DATE OF DEATH <u>Feb 9 - 1955</u> (Month) (Day) (Year)			
5. SEX: <u>male</u>		6. COLOR OR RACE: <u>white</u>		7. SINGLE, MARRIED, WIDOWED, DIVORCED, (Specify): <u>single</u>		8. DATE OF BIRTH: <u>June 1-1920</u>	
9. AGE last birthday: <u>34</u> yrs.		10a. USUAL OCCUPATION (Give kind of work done during most of work life, even if retired): <u>Farmer</u>		10b. KIND OF BUSINESS OR INDUSTRY:		11. BIRTHPLACE (State or foreign country): <u>Talbot Co Md</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>				13. FATHER'S NAME: <u>Bernard Slaughter</u>			
14. MOTHER'S MAIDEN NAME: <u>Annie E. Callahan</u>				15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unk.) <u>no</u> (If Yes, give war or dates of service)			
16. SOCIAL SECURITY No.: <u>none</u>				17. INFORMANT & ADDRESS: <u>Clara Lloyd Slaughter-wife</u>			
18. MEDICAL CERTIFICATION							
1. DISEASES OR CONDITIONS DIRECTLY LEADING TO DEATH: <u>824 X</u> Immediate cause (a) <u>Auto accident - broken neck + asphyxia</u> DUE TO Antecedent cause(s) (b) _____ Diseases or conditions, if any, giving rise to the above cause DUE TO stating underlying cause last (c) _____						INTERVAL BETWEEN ONSET AND DEATH	
11. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO THE DEATH BUT NOT RELATED TO THE DISEASE OR CONDITION CAUSING DEATH.							
19a. DATE OF OPERATION: <u>Feb 9-55-945 PM</u>				19b. MAJOR FINDING OF OPERATION:			
20. AUTOPSY? Yes <input type="checkbox"/> No <input checked="" type="checkbox"/>							
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.		21b. PLACE (Home, farm, factory, OF street, office bldg., etc.) INJURY <u>Co-road</u>		21c. (City or town) (County) <u>near Centerville - 2 mi</u> (State) <u>MD</u>		21d. HOW DID INJURY OCCUR? <u>Fell, or thrown from truck.</u>	
21e. TIME (Month) (Day) (Year) (Hour) OF INJURY <u>Feb 9-55-945 PM</u>		21f. INJURY OCCURRED While at <input checked="" type="checkbox"/> Not while at work <input type="checkbox"/>					
22. I hereby certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input type="checkbox"/> , and find that death resulted from: Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined cause <input type="checkbox"/> . SIGNATURE <u>W. Henry Fisher</u> M. D. ASSISTANT MEDICAL EXAM. <u>2/10-55</u>							
23. BURIAL, CREMATION, REMOVAL (Specify): <u>Buried</u>		DATE THEREOF <u>Feb. 12 1955</u>		NAME OF CEMETERY OR CREMATORY <u>Springhill</u>		LOCATION (City, town, or county) (State) <u>Easton, Maryland</u>	
DATE REC'D BY LOCAL REG. <u>2-11-55</u>		REGISTRAR'S SIGNATURE <u>Clara Armstrong</u>		24. FUNERAL DIRECTOR <u>Barton Bros. Centerville, Maryland</u>		ADDRESS	

BUREAU V. S.

FEB 21 1925

RECEIVED